Centers for Disease Control and Prevention
Advisory Committee to the Director

Summary Minutes of the July 31, 2003 Meeting

ATTENDANCE

Members present:

Dr. John O. Agwunobi
Dr. Stephanie Bailey
Dr. Marilyn M. Billingsly
Dr. Gail H. Cassell
Dr. Thomas R. Frieden
Dr. Robert L. Galli
Mr. Joseph M. Hogan
Ms. Ruth Katz
Ms. Sandra K. Mahkorn
Dr. Joe S. McIlhaney
Mr. Shepherd Smith
Dr. Eugene Washington

Members absent: Dr. Daniel Callahan, Mr. Alexander R. Lerner

Consultants present: Dr. Enriqueta Bond

Consultants absent: Dr. Robert E. Fullilove, Dr. Ellen MacKenzie, Dr. James Malcolm Melius, Dr. James Merchant, Dr. Thomas Vernon

Centers for Disease Control and Prevention participants: Dr. Julie L. Gerberding, Director; Ms. Verla S. Neslund, Acting Chief of Staff; Dr. Dixie E. Snider, Jr. Acting Deputy Director for Public Health Science.

AGENDA

An **overview of the Federal Advisory Committee Act (FACA)** was provided by Ms. Sheryl L. Gagnon, of the CDC Management, Analysis and Services Offices (MASO). She defined FACA's purpose, applicability to advisory groups, and the differences between their subcommittees and workgroups.

Integration. CDC Director **Dr. Julie Gerberding provided an overview of CDC** and its mission. Aside from its traditional work, now done in a global context, CDC has operated in Aurgent@ mode since in 9/11, with the smallpox vaccination program and circulating disease (West Nile virus, SARS, monkeypox). The unique core capacities of CDC's twelve organizational entities (Centers, Institutes and program Offices B CIOs) are increasingly linked horizontally to merge the expertise needed to address urgent problems. The Department of Health and Human Services (DHHS) is moving to a similarly horizontal structure. Interactions between the CDC, the FDA and the Centers for Medicare and Medicaid Services (CMS) have improved markedly. CDC and NIH research is increasingly complementary and their top management meets quarterly.

The Committee's role in the CDC's *Strategic Direction Initiative* (SDI) (Futures Initiatve) will

will be to: 1) *advise* from an outside-in perspective to provide a reality check on current and planned activity; 2) *act* in the SDI to help CDC face critical issues and *advocating* for program directions. That goes beyond funding and resource needs, to opening doors to engage new partners to optimize work; and 3) holding CDC *accountable* to maintain its effectiveness and the impact of its work.

Discussion included:

- *Peer review.* The SDI Workgroup is examining viable options for the intra- and extramural peer review across CDC.
- *Funding.* The 2003 CDC budget has not yet been finalized by Congress. However, before an across-the-board recision of 0.65%, CDC/ATSDR's appropriation had increased to $6.7 billion. An April 16, 2003 supplemental appropriations bill also allocated $16 million for SARS prevention/control and $100 million to help state/local health departments implement the smallpox vaccination program.
- *HIV.* An estimated 100,000 Americans have undiagnosed HIV. CDC is decoupling pre-test counseling from the process to promote HIV testing, and the new rapid HIV test allows testing in more non-traditional settings. The goals are to diagnose people and begin treatment to prevent unknowing HIV transmission, promote perinatal testing to begin retroviral treatment, support behavior change, work with community-based organizations, and link back to healthcare delivery systems. Work with high risk groups will continue to be a priority.
- *Collaborations.* The forging of new relationships with NIH was appreciated by the committee as crucial to promote more translation of interventions. Linkages were also urged with the Agency for Healthcare Research and Quality (AHRQ) and the healthcare delivery system.
- NCID's Avirtual Center@ with CMS is another CDC initiative to remove barriers to preventive practices through CDC's proof of principle evidence. Created with CMS' Quality Improvement Office, this seeks to speed the incorporation of interventions such as standing orders for vaccination into standards of care.
- The CDC/WHO relationship, demonstrably successful in the SARS response, is likely to grow ever closer with many opportunities for collaboration.

The **steps to determining CDC's strategic direction** were outlined by Ms. Kathy Cahill, Senior Advisor for Strategic Innovation. The CDC staff's average age is 46.3 years old (looming retirements demand attention to the next workforce); 32.5% are minorities (aiding diversity in developing interventions), and 58.2% is female. Less than 5% of the current budget targets global programs.

The SDI planning process is an open, participatory, data-driven process focused on critical issues. It works "outside in", starting with CDC's "customer". Its premise is that structure follows strategy and that transformation of an organization takes time. It focuses on the process and will integrate with other agency/program planning and budgeting, including GPRA; stresses communication and links to implementation. The structure for decision making and input includes four workgroups focusing on the Health System (renamed from the Public Health System Workgroup to include all stakeholders); Customers, Research, and CDC's role in Global

Prevention.

The committee agreed on the desirability of integration. *Discussion* included:

- The Health Systems, Global and Customer workgroups needs to have external involvement.
- The DHHS agencies' coordination was suggested to hear input concurrently from business, academia, etc. CDC, CMS and five other agencies have done this already and follow-up meetings will be held.
- CDC can lead change rather than managing it, emphasizing the process and strategic thinking as an ongoing imperative.
- It is difficult to effect change in a successful organization. External drivers creating an *opportunity* to change must be matched to an internal *need* to change.
- All of CDC's advisory committees will be involved in this process. Articulation to the staff/management of why change is desirable will be accomplished through employee survey/focus groups. The staff is beginning to realize that the pre-9/11 "normal" may not return, but their morale and devotion to their work remains unfailingly impressive. That is a treasure, and that altruism, commitment and motivation will not be endangered.
- The challenges to changing the "public health system" to a "health system" include getting the health departments to think in a systems approach. The message that public health works better with links to a variety of partners has to be explicit about including nontraditional partners and expanding opportunities to create those linkages.
- Despite excelling at measurement, CDC has had very few measures of its own impact. Part of the change process is impact-driven, and proving a return on investment is one of the best ways to ensure that the work advances.

A **data gathering exercise for the SDI** was held. The committee participated in a survey on the questions CDC is addressing.

The status of **CDC's Fiscal Year (FY) 2004 budget** was summarized by Mr. John Tibbs, Acting Director of the Financial Management Office (FMO). *FY04 Budget.* Since the FY04 budget requests were presented to Congress, Dr. Gerberding has testified six times to House and Senate committees on various aspects of CDC work.

The process of ***outsourcing CDC work*** was discussed. Dr. Gerberding stated that the President's Management Agenda, parallel to that of business several decades ago, pursues cost effective government to deliver the greatest impact for taxpayer dollars. In its scored implementation, CDC received "green lights" on 4 of its 5 components. The fifth is how human capital management is organized and personnel are supported, to ensure the most efficient workforce.

A competitive outsourcing initiative will identify government services potentially better provided by non-government workers. Once identified, an evidence-based study determines if private sector alternatives are in CDC's long- and short-term best interests. Workgroups will study this over time; the outcome is premature to predict.

A summary of **CDC's Master Facilities Plan** was provided by Mr. Carlton Duncan, of the

Office of Management and Operations (OMO). The committee underscored the importance that the integrity of CDC's work must not be hazarded, either by staff depletion or by inadequate facilities. Its work is often very dangerous. No academic center could continue to operate with the dilapidated facilities that CDC is only now finally able to replace. Dr. Gerberding reported President Bush's strong support for that.

In *discussion*, development of a budget and planning was reported to improve the similarly degraded Ft. Collins laboratories, where CDC's crucial vector control work is done. The committee asked to hear about the Ft. Collins improvement plan when possible.

An **Infectious Disease Update** focused on SARS, monkeypox, and West Nile Virus, was given by NCID Director Dr. James Hughes. A 1992 Institute of Medicine (IOM) report on microbial threats to health in the U.S. attributed the emergence of infection disease to six factors. One of these was microbial adaptation and resistance. Another report in 2003 broadened that list to add seven more, including poverty and social inequality, lack of political will, and intent to harm. He offered to provide copies of the final IOM report, in which 14 of the 21 recommendations either named or involved the CDC.

The ***SARS*** outbreak developed from one person in Hong Kong to >8400 cases, 29 countries, and >800 deaths. SARS demonstrated conclusively the link between public and clinical health. CDC's response involved >800 persons and ~100 deployments domestically and internationally. The WHO activated their Emergency Operations Center and their international networks of epidemiologist and labs collaborated practically daily. U.S. cases totaled 192 (33 probable and 159 suspected). CDC's preparedness for the coming season includes surveillance, clinical and lab teams, special studies and information technology, communication and education, and preparedness and response.

Monkeypox was spread in the U.S. through prairie dogs imported from Africa. Currently, 72 cases are under investigation and 37 are lab-confirmed. CDC and FDA embargoed the importation of certain rodents and prairie dogs. There have been 59 cases reported of ***West Nile Virus*** this season and evidence of the virus reported in 40 states. There are now two diagnostic tests for serum and CSF, and nucleic acid detection assays for initial diagnostic and confirmatory tests in blood (useful for donor screening). The CDC Website emphasizes West Nile prevention (AFight the Bite@). The disease grew from human infection in one state in 1999 to, in 2002, only four states without the virus' activity or human infections.

The lessons learned from global microbial threats pertain greatly to West Nile virus: strong national and global partnerships among the clinical, public health, laboratory, and veterinary communities; preparedness planning; proactive communications; and the need to expect the unexpected. Current tools provide an unprecedented opportunity to do what the IOM recommended to address infectious disease issues, and the new WHO Director is similarly interested in doing so. The committee's feedback was solicited on the CDC/NCID Website and on CDC's role as presented in the IOM report.

Discussion included:

- NCID has looked for a matrix in animals to anticipate and prevent possible future contagion.
- Some of the NCID monkeypox response team staff were also on SARS teams. The committee expressed concern at the staff's intense work for an extended time and the threat of burnout.
- CDC's quick and clear communication to the states during these outbreaks was commended, but the physical and budgetary limitations of both CDC and WHO response activities should be made known.

A summary of CDC's **Chronic Disease Prevention STEPS Initiative** was provided by NCCDPHP Director Dr. James Marks and Ms. Elizabeth Majestic. The cost of healthcare in the U.S. is ~30% higher than elsewhere. CMS expects that to increase (14% to 17%) by 2011, when the first of the baby boomers will reach 65, and then to double by 2030. Healthcare costs for a 65 year-old are four times that of a 45 year-old. The U.S. healthcare system is not sustainable and time to correct that is running out.

On top of that is an unprecedented epidemic of obesity, up 75% in adults in the last decade and tripled in children in the last 20 years. Diabetes has accelerated as well. SARS caused 830 deaths world-wide, but obesity is related to 1000 deaths per day. The Secretary and President vigorously support efforts to combat this. The Secretary reallocated this year's budget to provide $15 million to fund the first grants to states and larger communities to address obesity, diabetes and asthma. A prevention summit in April announced this program; applications are coming in and being reviewed.

In the past 18 months, CDC's Prevention Research Centers and the Schools of Public Health have identified and measured effective community interventions among racial and ethnic groups at high risk of cancer, obesity and diabetes. CDC also led development of the *Guide to Community Preventive Services*, a compilation of evidence supporting prevention interventions in a community. Its past leader, Dr. Stephanie Zaza, now leads the STEPS grant program to communities.

Ms. Majestic reported CDC's lead in developing the overarching "Steps to a Healthier U.S.: Putting Prevention First" Initiative, in response to the President's call.

- The current $15 million budget for cooperative agreements is expanded in the FY04 budget to $125 million.
- CDC is developing a Federal Register notice to invite business partners to promote a strategy to encourage responsible behavior (e.g., for obesity, by supporting reductions in food/drink fat content, portion sizes, etc.), and to advance a multi-disciplinary approach.
- To enlist other policy/decision makers, NCCDPHP developed a "Prevention Portfolio." The book's three documents describe the issues of chronic disease prevention and health promotion. They summarize the economics of the related health burdens, present the science of prevention and how that is the appropriate response, and success stories.

Discussion included:

- The ACF has the lead for a White House initiative to begin this fall for disadvantaged youth. CDC's collaboration with that would have greater impact. Mr. Shepherd offered to provide contact information.
- The increased focus on noncommunicable disease was welcomed, as it accounts for 70% of illness and death in the U.S. A balanced portfolio of approaches is needed. The analogy was made that public health succeeded in a population approach of fluoridating water, not encouraging people to boil their water.
- Since obesity is linked to physical activity, CDC is promoting public health involvement in land use and zoning and planning issues, to make it easier for people to exercise. The CDC Website has a Healthy Places site and the September issues of the *American Journal of Public Health* and the *American Journal of Health Promotion* will stress health and the built environment.
- An update was provided on the NCCDPHP's "Verb" media campaign to increase physical activity among children aged 9-13 years ("tweens"). After a year, tweens' recognition of the tag line ("Verb: It's what you *do*") has been gratifyingly rapid. An evaluation is being done of success in changing behavior.
- *Metrics are important in driving a program like this. Many people think others are fat, but not them. It is critical to your success to make the metrics and the link to disease easy to understand.* Two-thirds of people do underestimate their obesity status. Finally, there is debate over the messages about what food should be eaten. Such complex problems have to be overcome, though; the percentage of those >100 pounds overweight now is growing faster than those 20-30 pounds overweight.
- It was noted that the brochure on youth risk taking did not mention girls' risk of cervical cancer from HPV, and a pattern of not discussing infectious diseases such as STD seems present. Dr. Marks explained that the first round of grants target only obesity, diabetes and asthma. Much more needs to be done, but this is NCCDPHP's largest initiative to the communities, at $1 million/year; the average diabetes grant to entire states is ~$500,000/year. The initiative can help make changes, but the U.S. is still in the acceleration phase of the obesity epidemic, so stopping it will be a huge undertaking.

A brief presentation was provided of the **Research Officers Group Nominees (ROG).** The Workgroup's action constituted **a motion,** which was seconded by Mr. Smith and was **unanimously approved to forward these ROG candidates' names to the Director.**

Closing comments included a plan, as possible, to have a half-day tour of CDC at the next meeting, to be held after January 1, 2004.

I hereby confirm that this summary is accurate to the best of my knowledge.

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Verla S. Neslund, Acting Chair

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ATTACHMENT: ATTENDANCE

Members present:

John O. Agwunobi, M.D., M.P.H., Secretary of Health/State Health Officer, Tallahassee, FL

Stephanie Bailey, B.C., M.D., M.S.H.S.A., Director, Metropolitan Health Department, Nashville, TN. Past President, National Association of County and City Health Officers (NACCHO); has 65 of 80 credits toward his M.P.H.

Marilyn M. Billingsly, M.D., Associate Professor of Internal Medicine, St. Louis University, St. Louis, MO. Expertise in academic medicine and urban health, particularly among youth.

Gail H. Cassell, Ph.D., Vice President, Eli Lilly & Company, Indianapolis, IN. For Lilly, deals with public policy and infectious disease at Lilly and conducts work on infectious disease in developing countries.

Thomas R. Frieden, M.D., M.P.H., Commissioner, New York City Department of Health and Mental Hygiene. Worked with CDC as an Epidemic Investigation Service officer, and in TB Control Programs in New York City and India (for the World Bank). New York City=s health department is unique, acting in roles comparable to a large state. They have merged mental health, mental retardation and alcohol/drug services.

Robert L. Galli, M.D., Professor and Chair, Emergency Medicine, University of Mississippi Medical Center, Jackson, MS. Established Mississippi=s state-wide trauma center; now works with rural emergency departments, using telemedicine to deliver emergency care in unique way.

Joseph M. Hogan, President/CEO, General Electric Medical Systems, Waukesha, WI. GE Medical Systems is involved in healthcare around the world.

Ruth Katz, J.D., M.P.H., Associate Dean for Administration, Yale School of Medicine, New Haven, CT. As of 9/1/03 will be Dean of the George Washington School of Public Health. Served as counsel to the Subcommittee on Health and Environment on Capital Hill, has worked on CDC programs, and is a member of the National Vaccine Advisory Committee.

Sandra K. Mahkorn, M.S., M.P.H., M.S., Chief Medical Office for Health Information, Division of Health Care Financing, Department of Health and Family Services, Madison, WI. The state runs the Medicare/Medicaid services and link databases between programs.

Joe S. McIlhaney, M.D., M.P.H., M.S., Founder/President, Medical Institute for Sexual Health, Austin, TX. Began Austin=s *in vitro* fertilization program and started the Institute to educate the field and public in 1995. His work and interest in STDs is in part due to their effects of infertility.

Shepherd Smith, Founder/President, Institute for Youth Development, Sterling, VA. Has worked in the HIV/AIDS field since the mid-1980s. Began the Institute to provide a comprehensive approach for children that includes violence, sex, etc.

Eugene Washington, M.D., M.Sc., Professor/Chair, Department of Obstetrics, Gynecology and Reproductive Sciences; University of California, San Francisco, CA. Medical Director, Women=s Reproductive Health Career Development Center and Co-Director. UCSF/Stanford Evidence-Based Practice Center. On CDC staff for nine years.

Members absent:
Daniel Callahan, Ph.D., Director of International Programs, The Hastings Center, Garrison, NY
Alexander R. Lerner, Executive Vice President/CEO, Illinois State Medical Society, Chicago, IL

Consultants present:
Enriqueta Bond, Ph.D., Board of Scientific Counselors, National Center for Infectious Diseases; President, Burroughs Wellcome Fund, Research Triangle Park, North Carolina. Has worked with the Institute of Medicine (IOM) for 20 years; presently on its Council; Chairs the National Library of Medicine=s Board of Regents.

Consultants absent:
Robert E. Fullilove, EdD., CDC Advisory Committee on HIV and STD Prevention; Associate Dean, Community and Minority Affairs, Columbia University School of Public Health
Ellen Mackenzie, Ph.D., Chair, National Center for Injury Prevention and Control, Director, Center for Injury Research and Policy, Johns Hopkins Bloomberg School of Public Health; Baltimore, Maryland
Ellen MacKenzie, Ph.D., National Center for Injury Prevention and Control, Director, Center for Injury Research and Policy, John Hopkins Bloomberg School of Public Health
James Malcolm Melius, M.D., Dr.P.H., Board of Scientific Counselors, Agency for Toxic Substances and Disease Registry; Director, New York State Laborers= Health and Safety Trust Fund, Albany, New York.
James Merchant, M.D., Dr. P.H., Board of Scientific Counselors, National Institute for Occupational Safety and Health; Professor and Dean, University of Iowa College of Public Health, Iowa City, Iowa
Thomas Vernon, M.D., Acting Chair, National Advisory Committee to the Director, National Center for Environmental Health; Vice President, Public Health and Medical Affairs Policy, Merck Vaccine Division, Merck & Company, Inc.

Centers for Disease Control and Prevention participants:
Julie L. Gerberding, M.D., M.P.H., Director
Verla S. Neslund, Acting Chief of Staff
Dixie E. Snider, Jr. M.D., Acting Deputy Director, Public Health Science